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ABSTRACT

This set of seven issue briefs considers six important community-based services for children with serious mental or emotional disorders that some states provide as mandated rehabilitation services under the federal Medicaid law. The materials are designed to help state policymakers develop appropriate rules for covering community-based services for this population. Following a brief introduction, the first brief offers a general discussion of issues involved in funding child mental health services through Medicaid, such as Medicaid reimbursement as part of overall state mental health policy. Each of the six numbered issue briefs lists the goals and purposes of a service, describes research to support its effectiveness and provides a composite definition of the activities covered, drawn from one or more state definitions as approved by the federal government. Also given is information on state definitions of qualified providers, lengths of treatment, prior approval and other factors. The six briefs address the following issues: (1) behavioral/therapeutic aids; (2) intensive in-home services; (3) child respite care; (4) after-school programs; (5) summer camps; and (6) therapeutic nurseries and preschools. (DB)

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Covering Intensive Community-Based Child Mental Health Services under Medicaid. A Series of Issue Briefs.

Bazelon Center for Mental Health Law

Chris Koyanagi and Rafael Semansky

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Covering Intensive Community-Based Child Mental Health Services Under Medicaid

Introduction

Federal Medicaid law requires states to provide rehabilitative services to children when necessary to treat a physical or mental condition or to restore, maintain or prevent deterioration in a child's functioning. The services must be furnished by a licensed practitioner of the healing arts. The federal definition of these mandated rehabilitation services under Medicaid is broad, but not defined in detail. As a result, states have varied descriptions of psychiatric rehabilitation services for children.

A number of states cover several of the services that have a strong research base.[1] These include intensive in-home services, day treatment and case management. Other services, also with research to support their effectiveness and seen as extremely important by families and children, are less frequently included in state definitions. Among these are behavioral or therapeutic aides, therapeutic nursery or preschool programs, after-school programs, summer therapeutic camps and child respite care.

This packet includes information on six important community-based services for children with serious mental or emotional disor-

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ders that are covered under the federal Medicaid law. The first pamphlet offers a general discussion of issues involved in funding child mental health services through Medicaid. Each of the six numbered issue briefs lists the goals and purposes of a service, describes research supporting its effectiveness and provides a composite definition of the activities covered, drawn from one or more state definitions as approved by the federal government. Also given is information on state definitions of qualified providers, lengths of treatment, prior approval and other factors.

This collection of pamphlets can assist state policymakers in designing appropriate definitions of community-based mental health services for children with serious mental or emotional disorders. The Bazelon Center urges state policymakers to review these materials as they begin to develop their own definitions of rehabilitative services. In adapting the definitions to a state's mental health system and goals for a particular service, planners may need to shorten or expand the language in these issue briefs, depending on the degree of detail normally included in their state's Medicaid program.

These materials are designed to assist state officials in developing appropriate definitions of child mental health services and to help families and other child advocates understand the scope of Medicaid coverage of these services. By reviewing their own state's Medicaid rules, families and advocates can find out whether these services are actually available in the state. If not, they can encourage state officials to review these materials and urge them to make the changes necessary for Medicaid-eligible children with serious mental or emotional disorders to have access to an appropriate array of effective community mental health services.

Washington DC
April 2001

Note

1. Bazelon Center for Mental Health Law, *Making Sense of Medicaid for Children with Serious Emotional Disturbance* (2000).

We are especially grateful to the directors and staff of the Foundation for Child Development and the Marion E. Kenworthy-Sarah H. Swift Foundation for providing the support that enabled the Bazelon Center to develop and produce the information in this packet.

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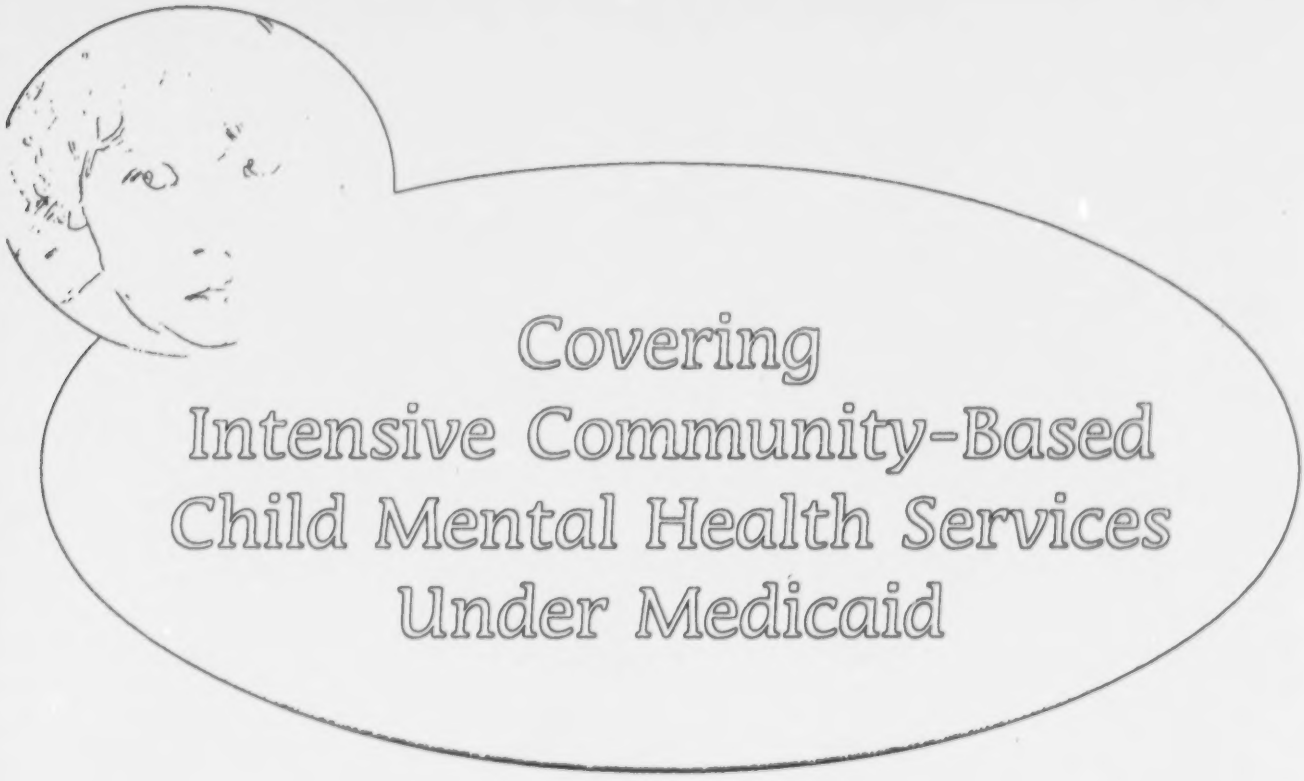

Covering Intensive Community-Based Child Mental Health Services Under Medicaid

Defining Children's Mental Health Services

To include a new definition of child mental health services under a state Medicaid plan, details must be worked out with the state's Medicaid agency and presented to the federal Health Care Financing Administration (HCFA) regional office staff for approval. Normally, these decisions do not need additional approval by the national HCFA office in Baltimore unless the state is requesting a waiver of the federal Medicaid rules (such as a waiver for managed care or for home- and community-based services).

Securing approval for a new definition of a child mental health service, such as those described in this series, is not always easy. Usually, the state mental health authority takes the first steps, sometimes in concert with other child-serving agencies such as child welfare or juvenile justice. These agencies are primarily concerned with the development of an appropriate and cost-effective array of services for children in need, and view Medicaid reimbursement as a tool to enhance state service-system policy.

State Medicaid agencies, on the other hand, are responsible for the overall objectives of the state's Medicaid program. They need to control costs while ensuring appropriate access by all eligible popu-

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lations to a range of health and mental health services. They must also consider their own relationship with the regional HCFA office. These factors all come into play in securing approval to create a new service definition.

Medicaid Reimbursement as Part of Overall State Mental Health Policy

Medicaid reimbursement needs to be seen as part of a state's broader vision of a community system of care for children. This principle is underscored in interviews with both mental health and Medicaid officials in states that have comprehensive Medicaid definitions of intensive community mental health services for children. These states focus on furnishing appropriate individualized services to meet each child's needs in a flexible manner and to support children in their home communities, rather than assigning children arbitrarily into slots for standardized care.

An understanding that reimbursement is designed to support this vision will facilitate the Medicaid agency's approval of new service definitions. Once the state has made a commitment to provide services to children in this manner, it becomes a win-win situation to secure federal assistance in paying for the services because all child-serving agencies will benefit, as will children and their families.

Concerns Raised by State Medicaid Agencies and HCFA

According to state officials interviewed for this project, certain issues often arise in negotiations with Medicaid agencies. Some of the key issues are:

◇ Service cost, particularly in the context of a state's ability to predict and control future costs. Uncertainty concerning the size of the eligible population or the utilization rate if the service is defined in a certain way can delay approval of a definition.

◆ The differences between each covered service must be clear. For example, state mental health authorities have been asked to clarify how home-based services are different from case management or behavioral aide services in order to justify having separate definitions and other requirements for each service.

◆ Medicaid agencies are concerned about paying more than once for a particular activity, or paying for a high-cost service when a lower-cost service was actually delivered. For example, definitions of home-based services often include linking families to other supports. This activity can be funded under Targeted Case Management, but if it is furnished as part of a home visit, Medicaid cannot also be billed for Targeted Case Management.

◆ Services under Medicaid must be furnished to the diagnosed, Medicaid-eligible individual—here, the child. Family-support services are not covered as a rehabilitation service and definitions of

services must ensure that providers do not bill for them.

- Bundled rates for payment can be problematic. For some services, Medicaid agencies may be reluctant to allow a provider agency to bill for its entire program at a bundled rate, rather than billing individual components or making some components non-Medicaid-reimbursable. However, negotiations around appropriate definitions and provisions designed to prevent runaway costs and ensure quality can overcome this resistance.
- The definition of a children's service may be questioned if the Medicaid agency has not previously approved a parallel adult service. This is a particular problem in states where the psychiatric rehabilitation option for adults is not included in the state Medicaid plan. But it also can arise if an adult definition does not readily lend itself to child services.
- Medicaid officials also review closely definitions relating to appropriate professional supervision of services, medical necessity and utilization review.

Addressing Medicaid's Concerns

Some of the ways state mental health authorities have overcome these concerns are:

- Careful development of definitions. Definitions are more likely to be approved when they clearly meet the child mental health system's goals and objectives and also have language similar to the state's adult service definitions or to language approved by federal Medicaid for other states.
- Covering some services as variations on another. For example, after-school and summer programs that meet the definition for day treatment or behavioral aide services that meet definitions under outpatient visits.
- Gathering and presenting data on cost-effectiveness studies for the service and projecting reductions in institutional or other costs if the service became available.
- Seeking Medicaid approval of general language on the psychiatric rehabilitation service for children and retaining authority within the mental health agency for specifying the exact details.
- Negotiating the exact rate for providers to bill when reimbursement will be for a bundled package of services, thus assuring appropriate cost controls for Medicaid.
- Using state mental health funds (or blended funds that include resources from other state agencies) for the Medicaid match.

As in many such processes, the key factor for success has been individual negotiations with concerned Medicaid officials to explain the goals and objectives of the mental health program. The negotiations may be protracted, particularly if the Medicaid officials are not

familiar with mental health service delivery issues. However, many state mental health authorities have found that by being assertive and persistent issues can be worked out.

Mental health officials should also provide to Medicaid officials information that will help them fulfill their own obligations. Medicaid agencies need to know:

- that the proposed services are effective;
- what the anticipated utilization rate and costs will be; and
- how furnishing those services will help the state deal with significant problems for children living in the state, such as those suffering from abuse or neglect, those at risk of foster care placement or those in (or in danger of coming into) contact with juvenile justice.

HCFA Approval

The state Medicaid officials will then need to negotiate approval from the federal HCFA regional office. They are most likely to succeed when armed with good definitions that comport with federal law as interpreted in other states and other federal regions, along with good arguments for the need to cover the particular services. While HCFA regional offices are somewhat independent and do not necessarily follow each other's lead, federal law protects states in this negotiating process. The EPSDT mandate of Medicaid requires that states provide children all necessary services to treat their condition, provided the service is covered by federal law. Courts have found that inclusion of a service in another state's plan (particularly in several states' plans) establishes the service as covered by federal law.

Managed Care Considerations

Another factor that weighs in the decision-making process is whether the definition will apply in fee-for-service Medicaid or will be part of a capitated managed care contract. When services are included in managed care arrangements, Medicaid officials are less concerned about added costs to the program, since these are limited by the capitation rate. Accordingly, states and HCFA tend to approve the listing of new services in these contracts more readily than they approve them for fee-for-service Medicaid programs. However, all the services described in these issue briefs have been incorporated in both fee-for-service and managed care Medicaid arrangements.

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1. Behavioral/therapeutic aids
2. Intensive at-home services
3. Child respite care
4. After-school programs
5. Therapeutic summer camps
6. Therapeutic nurseries and preschools

#1

Covering Intensive Community-Based Child Mental Health Services Under Medicaid

Behavioral/Therapeutic Aides

An important component in an effective system of care for children with serious mental or emotional disorders is the presence of an adult-someone who is not a member of the family-to mentor and assist the child at various critical times of the day. This para-professional position is called by various names; in Medicaid the most common terms are "behavioral aide" and "therapeutic aide."

Service Description

Behavioral aides have proven a protective factor in the lives of children with serious mental or emotional disorders. Their focus is social support and social skills development, building a youngster's competencies and confidence and providing school support. Use of behavioral aides can prevent removal of a child from home and avert delinquency. Specifically, a behavioral aide may provide both crisis intervention and rehabilitation services, such as teaching the child appropriate problem-solving skills, anger management and other social skills.[1] In many programs, behavioral aides provide assistance at one or more of the following times: in the early morning to help the child get ready for the day; during the school day, as they accompany the child; after school, engaging the child in constructive activities in the community; and at bedtime, helping the child end

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the day and retire. For some children, behavioral-aide services may be needed at all of these times, at least for a while.

Research Literature

Behavioral aide services have been evaluated, although there is not a large body of research. However, families and programs that have used behavioral aides have positive views of the service and the research indicates positive findings. Behavioral-aide services can improve a child's school attendance and performance, attitude toward school, and peer and family relationships, and reduce the likelihood of a child's being physically violent or initiating drug or alcohol use.[2]

Medicaid Coverage

Behavioral-aide services can be covered under the Medicaid psychiatric rehabilitation service, as long as they are recommended by a physician or other licensed practitioner and furnished to improve or maintain a child's functional level or to reduce disability caused by a mental disorder. In some states, the service is included in a broader definition of "wraparound services" under psychiatric rehabilitation services.

Coverage in States

Five states have detailed definitions of services of behavioral aides.[3] State rules covering behavioral aide services often address the following areas:

- Purpose of service: to avoid inpatient or residential placement or other out-of-home care, to avoid continued institutional placement beyond the point of stabilization of behavior and control of symptoms, to ensure a smooth transition from institutional to community placement, or to avoid more restrictive educational placement. Behavioral management services stabilize, reduce or eliminate undesirable behaviors that put children at risk of being served in restrictive settings.
- Eligible child: Generally, behavioral aide services are targeted to a child with a severe mental or emotional disorder, although in some states the service is available to children who are at risk of a serious emotional disorder. The target group may be further clarified. For example, one state's criteria target children who exhibit severe maladaptive or disruptive behavior, are unable to perform activities of daily living due to severe symptoms, or have severe emotional problems associated with medical conditions or sexual abuse or physical abuse or addiction.
- Activities: Behavioral aides implement a behavioral management plan, furnishing services such as training and reinforcement in social and behavior management skills and building youngsters' competencies and confidence. Behavioral aides help a child both to learn

and to observe appropriate behavior. Other services include crisis intervention; parent education and assistance to parents in managing their child's symptoms and behaviors; and providing school support and other specific psychosocial rehabilitative activities described in the child's treatment plan.

- Residence of child: Services are provided to children living at home or to children transitioning back home from out-of-home care.
- Goal of services: to enhance a child's ability to function in family, school and community.
- Service planning: Services are furnished as part of a multidisciplinary treatment plan developed with the family and, as appropriate, with the child's involvement and approval. Supervision by a mental health professional is required. If more than one individual provides behavioral aide services to a particular child, coordination between them is required.
- Delivery site: Services may be furnished in any setting appropriate to meet the child's needs, including home, school and community.
- Staff qualifications: These are para-professional positions, often requiring a bachelor's degree and some experience. Behavioral aides may be required to show evidence of an ability to relate to emotionally disturbed children. Specialized training (specific to the state) is usually required and some experience in human services. Members of the child's family are not eligible providers. Certification of providers or provider agencies may also be required.
- Length of intervention: Services are often time-limited and tied to an identified need to achieve certain outcomes, such as acquiring desired adaptive behaviors or eliminating maladaptive behaviors.
- Prior approval: Some states require prior authorization of behavioral aide services. Periodic reviews of progress are also sometimes required.
- Services not covered: States specifically exclude formal education, job training and other vocational services, and any services that are not included in the child's plan of care. Activities that are purely recreational or social and have no therapeutic component or purpose are not covered.
- Other issues: Behavioral aide services are often required as part of a comprehensive program of community-based services. Collaboration between providers of behavioral aide services and any other community provider of services to the child is mandated.
- Terms: States variously describe behavioral aides as behavioral aides, providers of therapeutic staff support, mentors, attendant care givers or therapeutic aides, among other terms.

◆ Issues in securing Medicaid approval: Appropriate professional supervision of behavioral aides and inclusion of the service in a child's treatment plan are important factors in securing approval for this service. It is also important to clarify the aide's specific activities and to ensure that these activities are actively provided during times when Medicaid is billed for the service. In other words, the aide must be assisting the child in ways that improve daily functioning (including modeling appropriate behavior), not merely accompanying the child from place to place.

Importance to Families

"The behavior management specialist person came in and he got back into the classroom flow...His behavior was managed. It was under control. When that person was pulled out, within two weeks things started regressing and we ended the school year with him just about being expelled again."[4]

"The behavior management service is the key to keeping him at home."

Notes

1. Burns, Barbara J., Hoagwood, Kimberly and Patricia Mrazek, Effective Treatment for Mental Disorders in Children and Adolescents. Clinical Child and Family Psychology Review, Vol. 2, No 4 (1999).

2. Terms used in the research literature to describe these staff positions vary, and include mentors, behavioral or therapeutic aides. Burns, Barbara J., et al., note 1; Owley, Gordon and Joan Sternweis, Effectiveness of Contracted Services in Individualizing and Tailoring Mentor Programming for Children with Severe Emotional Disturbance in a Public System, Proceedings of the Annual Research Conference, Research & Training Center, Florida Mental Health Institute, University of South Florida, Tampa (1997).

3. Nebraska, New Mexico, North Dakota, Pennsylvania and West Virginia. Bazelon Center for Mental Health Law. Making Sense of Medicaid for Children with Serious Emotional Disturbance. Washington DC: Author (September, 1999).

4. Koyanagi, C. and Semansky, R. Report on Unmet Need for Child Mental Health Services in New Mexico. Washington DC: Bazelon Center for Mental Health Law (March 2001).

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#2

Covering Intensive Community-Based Child Mental Health Services Under Medicaid

Intensive In-Home Services

Intensive in-home services can preserve family integrity and prevent unnecessary out-of-home placements. Intensive in-home services include case management, therapy, education and training for families, and services to improve a family's coping skills. In-home services may also be called family-preservation services, home-based services, family-centered services, family-based services or intensive family services.[1]

Service Description

In-home services are normally provided only to children with serious emotional disorders. They are designed to improve the child's ability to function within the family, thus avoiding out-of-home placement. In-home services can be funded by mental health, child welfare and juvenile justice systems.

Research Literature

According to the Report on Mental Health by the Surgeon General of the United States, there is a "strong record of effectiveness for home-based services, which provide very intensive services within the homes of children and youth with serious emotional disturbances."[2] The report cites two well-researched models: family-preservation programs used in child welfare systems and multisystemic therapy (MST), which is generally used in juvenile justice systems.

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- **Family-preservation programs**: Studies of these programs have found high rates of effectiveness. Seventy-five to 90 percent of children in such programs did not require out-of-home placement. Further, their verbal and physical aggression diminished at the same time that service costs were reduced.[3] Home-based services have also achieved fiscal savings.[4]
- **MST programs** are designed for delinquents. They have been shown effective in real-world settings when implemented in accordance with the manual and with support from the originators of the program. MST is more effective than usual community services in decreasing adolescent behavioral problems and improving family functioning. Youth have fewer contacts with the justice system, show less aggression and commit fewer violent offenses, while families report increased cohesion.[5] MST also has been shown to lower costs.[6]

Medicaid Coverage

Thirty states cover intensive in-home services under Medicaid,[7] of which seven have detailed descriptions. Intensive home-based services are covered under the Medicaid rehabilitation option. State rules covering intensive in-home services often address the following issues:

- **Purpose of service**: Services are furnished for the restoration, modification and/or maintenance of social and personal adjustment and basic living skills or to prevent psychiatric deterioration. Services are to reduce or manage symptoms and/or behaviors resulting from serious emotional disorders that interfere with the individual's ability to function appropriately. In some states, in-home services are used primarily to stabilize a crisis situation and/or defuse or avert a crisis.
- **Eligible child**: Intensive in-home services are generally provided to children with serious mental or emotional disorders during times of crisis, when the child is at risk of out-of-home placement, experiences a high level of stress in his/her family unit, or has just returned from an out-of-home placement. Families may be asked to sign an agreement for in-home services and must be willing to participate.
- **Activities**: Intensive in-home services may include assessment, case management, crisis management, counseling and skills training designed to assist the child to interact appropriately within the context and demands of the home environment. Collateral services are provided to help the family build skills for coping with the child's disorder. Counseling may include individual or family therapy. Behavior management, problem-solving and social, communications, self-help and living-skills training for the child, and parenting skills training are often included. Parent-mentoring services can also be covered. Medication services and medication management and training are included as well. Crisis response is an

integral part of in-home services. Services may also include assistance in household management, as related to effective treatment and services for the child. All of the services are flexible and tailored to each individual child's needs and all must be available 24 hours a day, seven days a week. Services have a holistic perspective and involve working in collaboration with the community to access and coordinate a full range of supports and services.

- **Residence of child**: Services are furnished to children living in their natural or permanent homes or residing in out-of-home placements but transitioning back to their families.
- **Goal of services**: to enable a child to live at home with the skills necessary to ensure that the home is a safe and successful placement. Services promote normal development, improved peer relationships and healthy family functioning, and are designed to strengthen and preserve the child's home environment, ensure safety and improve the family's ability to care for and protect the child successfully. The services are developed to address each child's rehabilitative needs individually and meet each child's developmentally appropriate goals.
- **Service planning**: Appropriate assessments are required to document the need for in-home services. Services may be furnished by a single staff person or through a multi-disciplinary team approach. Service planning must be child-centered yet also family-focused, based on an assessment of child and family strengths and needs. Families participate in service planning and may be required to sign an agreement for care.
- **Delivery site**: Services are furnished when and where the needs of the child can best be met—in the child's home or at work, in an education setting or in any other location.
- **Staff qualifications**: Staff must have appropriate training and preparation. Cultural competence is an issue. Services must be recommended and supervised by a qualified mental health professional. Workers may be given training in symptoms of medication reaction as well as cultural competence and other issues. In some states, providers must have an appropriate degree with advanced training in the delivery of family-based services. Staff may be required to undergo a background check to ensure safety of the child and family.
- **Length of intervention**: Intensive in-home services are often furnished for a limited time in order to stabilize a situation. The intensity varies depending on the child's situation; services may be furnished from two to 20 or more hours per week, based on need. Services are offered for periods lasting from several weeks to several months, but are intended to be a time-limited response (although there are no arbitrary cut-off points).

- **Prior approval:** The appropriateness of intensive in-home services must be determined, based on the severity of the child's problems. Generally the services are approved only if they will avert an out-of-home placement or if the child is returning to the community from an out-of-home placement.
- **Services not covered:** In some states, emergency services, recreation and respite care are explicitly excluded. Case management services may not be billed separately for times when home-based services are being reimbursed, since case management is part of in-home services.
- **Other issues:** Child-to-provider ratios are low. In some states providers work with just one or two families at a time so they can work intensely with each; in others the ratio may be 1:15. Services are furnished at times convenient to the child and family, specifically including evenings and weekends. Workers can be reimbursed for travel time and for mileage. Hours of availability are flexible.
- **Issues in securing Medicaid approval:** Intensive in-home services must focus on the identified client's problems and needs as it relates to the home environment. Services to the family must have the purpose of treating the child; for example, family therapy is covered but individual therapy for a family member is not.

Importance to Families

Programs are committed to empowering families, instilling hope and assisting families in setting and achieving goals and priorities for their child and the family.

Notes

1. Burns, Barbara, Hoagwood, Kimberly & Patricia Mrazek, Effective Treatment for Mental Disorders in Children and Adolescents, *Clinical Child and Family Psychology Review*, Vol 2, No 4 (1999), p 219.
2. *Mental Health: A Report of the Surgeon General*, U.S. Department of Health & Human Services, Washington DC (2000) p. 175
3. Ibid.
4. Hinckley, E.C. & W.F. Ellis, An Effective Alernative to Residential Placement: Home-based Services. *Journal of Clinical Child Psychology*, 14(3) (1985), 209-213
5. Surgeon General's report, note 2.
6. Burns et al., note 1.
7. Alabama, Alaska, Arizona, California, Delaware, Florida, Illinois, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nevada, New Hampshire, North Dakota, Oklahoma, Oregon, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, Washington and Wisconsin. Bazelon Center for Mental Health Law. *Making Sense of Medicaid for Children with Serious Emotional Disturbance*. Washington, DC: Bazelon Center (September 1999).

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#3

Covering Intensive Community-Based Child Mental Health Services Under Medicaid

Child Respite Care

Respite care, as the name implies, provides a break. Because Medicaid is a health care program, reimbursing for services furnished to a covered individual, the respite services must be provided for the child. Accordingly, the service is *child* respite care, although respite also benefits the family and other caregivers.

Service Description

Respite services temporarily suspend the child's primary placement or primary caregiving and provide a short-term intervention, separating the child from caregivers for a few hours, overnight, a weekend or another relatively short period of time. As mental health systems increasingly place children in less restrictive and more family-like environments, the need for respite services becomes more and more crucial to maintain the integrity of the community placement.

Research Literature

The Report on Mental health by the Surgeon General of the United States defines respite care as "assisting families with the practicalities of living and attending to the needs of all family members" and categorizes it as part of family support services.[1] Although there is limited research on respite care as a single service, many positive

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effects have been reported in controlled studies and evaluations, often on populations with other disabilities.[2] Respite care is also a key aspect of wraparound services, for which a significant body of research indicates effectiveness in avoiding institutional placements and helping a child to live at home with a family or foster family. One study that looked specifically at respite care for children with serious emotional disturbance examined Vermont's 10-year program. This study found that children who received respite care experienced fewer out-of-home placements than children on a wait list.[3]

Medicaid Coverage

Child respite services can be covered under the rehabilitation option, if correctly defined (see issues in securing Medicaid, below).

Coverage in States

Eight states have detailed definitions for child respite care.[4] These definitions often address the following issues:

- **Purpose of service**: Respite services are short-term and temporary direct care and supervision for the child. Respite relieves a stressful situation and is designed to de-escalate a potential crisis situation and/or provide a therapeutic outlet for a child's emotional problems. Respite services, in combination with other active clinical treatment, are designed to avoid institutional placements, particularly long-term residential placements, and to defuse crises.
- **Eligible child**: Children with serious mental or emotional disorders who live in the community, either in the family home or in therapeutic foster care, are eligible. In some states, respite care is further limited to children who, while not yet in crisis, show signs of decompensation or other signs of looming crisis and would likely require more intensive services if child respite services were not available. Priority may be given to the most challenged children and those who have previously been in out-of-home placements.
- **Activities**: Respite programs can use various methods to provide supervision and structured services that will meet the child's basic health, nutritional, daily living and treatment needs during a brief period. The services are generally flexible and tied to the particular needs of a child and family. Families may request when and how respite services are to be furnished. Specific activities include behavior management interventions, supportive activities, mentoring, social skills training and observation of the child.
- **Residence of child**: Children living at home, in foster care or in a therapeutic foster care situation may be eligible for respite care.
- **Goal of services**: The goal is to prevent permanent disruption of a child's placement by providing rest and relief to children and helping them functioning as independently as possible. At the same time, respite often also offers rest and relief to caregivers.

◆ **Service planning:** Respite services are generally seen as one component in a full array of community mental health services provided through a wraparound model. Respite is often provided on a planned basis at certain times during a week or month, but usually is available on short notice as well, at times of emergency. Families are typically included in all decisions regarding respite services.

◆ **Delivery site:** Respite services can be furnished in the child's home, in another home in the community, in a therapeutic foster home, in a residential treatment facility, in a respite center or in a camp, recreational facility or other community location. When furnished in a residential program, respite care does not necessarily include the cost of room and board.

◆ **Staff qualifications:** Respite services are furnished by trained respite workers. Providers are usually required to be of a minimum age, to have experience working with children and specialized training in working with children with serious mental and emotional disorders, and to be supervised by a qualified mental health service provider. A frequent requirement is that mental health consultation be available for those furnishing the care. In some states, behavioral aides are defined as furnishing respite care along with other services (see Bazelon Center Issue Brief #1). States report that continuity of respite workers is important, so that children do not have to adjust to new providers.

◆ **Length of intervention:** Respite services can be anywhere from one to a few hours in length or from a weekend to a week or more in an alternative placement. Services may be furnished on a regular basis, such as after school or at night.

◆ **Prior approval:** For respite services to be found medically necessary for a particular child, the child must have a mental health condition that necessitates short-term relief away from the primary community home or caregiver. Physicians or other mental health professionals must generally approve respite as part of a comprehensive plan of care under an individualized treatment plan. Service necessity may be reviewed periodically.

◆ **Services not covered:** Services designed solely to give caregivers a break from looking after a child with serious emotional disturbance are not covered by Medicaid. Respite must be focused on the needs of the client child. Respite care does not include the cost of room and board when residential placements are used, except when the care is furnished in a location approved as a residential provider under the state Medicaid plan.

◆ **Issues in securing Medicaid approval:** Respite services must be defined to provide an intervention for a diagnosed individual. Providing a break for a caregiver is not sufficient and is not by itself a

Medicaid-covered service. However, state definitions often refer to this additional benefit of providing child respite care. Respite is more commonly covered under managed care contracts than fee-for-service Medicaid, but can be covered under both if the definition is specific and clearly focused on alleviating symptoms or preventing functional deterioration and thus avoiding the child's future out-of-home placement.

Importance to Families

In the Vermont study cited above, families whose child received respite services said they were more optimistic about caring for their child at home in the future. They reported a reduction in stress for both family and child and an improvement in family relations. Families in Vermont called respite care their top need.

Notes

1. *Mental Health: A Report of the Surgeon General.* U.S. Department of Health & Human Services, Washington DC (1999), p. 188.

2. Ibid, p. 189.

3. Bruns, Eric, Findings presented at the Federation of Families for Children's Mental Health, 9th Annual Conference. Georgetown University, Washington DC (1997).

4. *Making Sense of Medicaid for Children with Serious Emotional Disturbance.* Washington, DC: Bazelon Center (September 1999).

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#4

Covering Intensive Community-Based Child Mental Health Services Under Medicaid

After-School Programs

Children with serious emotional disturbance often require structure in their lives, and the period between the end of school or a day treatment program and the time their caregivers are available can be fraught with danger. After-school programs can bridge this gap.

Service Description

After-school programs take different forms. Some are school-based and operate much like a day treatment program, but without the provision of formal education. Others are freestanding programs in the community, and still others are specific services offered after school, such as behavioral aides or mentors. (Behavioral aide after-school services are discussed in Bazelon Center Issue Brief #1.) Programs target children and youth with serious emotional disturbance and sometimes also children at particularly high risk of serious emotional disturbance. Some programs specialize in services for teenagers, aiming to increase their independent-living skills and guide them through adolescence. Some programs focus on youth who are already in trouble or who have had contact with the juvenile justice system.

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Research Literature

There is no separate literature on the effectiveness of after-school programs. However, in most programs the services offered are similar to those provided in day treatment programs, for which the research shows positive gains. Seventy-five percent of youngsters in day treatment programs have shown academic and behavioral improvement, reduction in or delay of hospital and residential placement and a return to less restrictive school placements.[1]

Medicaid Coverage

After-school programs can be covered as Medicaid clinic services or through rehabilitation services. Medicaid rules require clinic programs to have physician supervision and are more clinically oriented. Programs funded through the rehabilitation service emphasize maintaining or improving a child's level of functioning.

Coverage in States

Seven states specifically define their after-school services.[2] State rules covering after-school programs may address the following issues:

- **Purpose of service**: After-school programs can offer many of the services provided in day treatment programs but can also meet other needs. Some provide additional academic tutoring (not Medicaid-reimbursable) and all can offer a safe and supervised environment for young people who may otherwise be likely to engage in unsociable behaviors. Building social and life skills is emphasized. These programs also offer recreational activities (not Medicaid-reimbursable) or therapeutic recreation.
- **Eligible child**: school-age children. Some programs require standardized tests of the child's functioning in order to determine eligibility for the program.
- **Activities**: individual and group psychotherapy, counseling, occupational training, psychosocial skills training with emphasis on interpersonal and problem-solving skills, recreational therapy, crisis intervention and family services. Independent-living skills, such as money management and budgeting, meal preparation, parenting and other life skills may be offered to older children. Art and music therapy may also be part of the program and physician services may be offered. Programs may also engage youths in community-service activities.
- **Residence of child**: Children live in the community.
- **Goal of services**: After-school programs have as their goal remediating significant impairments and improving the child's functioning. Programs aim to ensure that children can remain in the community and live with their families. Related benefits are providing a safe and structured environment in the hours between the end of school and the time a parent will return from work.

- **Service planning**: Services are offered as part of the child's individualized plan of care, developed through a treatment team with the family's and the child's participation. In some states, a physician's order or physician supervision is required. In most, an interdisciplinary team, generally including a physician, works with the family to authorize the plan of care.
- **Delivery site**: After-school programs can take various forms. Many are located on school grounds or at community programs, such as youth centers. Some after-school programs are more individualized, providing services, such as behavioral aides (see Issue Brief #1) in a variety of locations.
- **Staff qualifications**: Rules on the staff of after-school programs vary, depending on the type of program and the services offered. Professional staff are available, either on site or through consultation agreements. Other staff must usually meet specific state standards regarding basic education and specialized training and/or experience.
- **Length of intervention**: Some programs specify a length of time for such services, while others are more open-ended. Generally, children must attend such programs for a minimum number of hours a day or days per week. Limits on length of stay range from a few weeks for crisis-oriented programs to more than one academic year.
- **Prior approval**: Separate rules on prior approval are usually promulgated for these programs. The programs generally fall within the same guidelines as day treatment (or in the case of behavioral aide and mentor programs, within those guidelines).
- **Services not covered**: Education services, such as tutoring, are not a covered activity in after-school programs. Recreation without a therapeutic goal is also not covered under Medicaid.
- **Issues in securing Medicaid approval:** An after-school program can be listed under Medicaid as a day treatment program if it meets the state's standards for day treatment. Under these circumstances, other Medicaid services, such as clinic services, cannot be billed separately. Alternatively, the specific services furnished after school, such as counseling, behavioral aide, etc. can be individually billed. All services should be part of the child's plan of care and supervised by a qualified, licensed professional, as must all Medicaid services.

Notes

1. *Mental Health: A Report of the Surgeon General*, U.S. Public Health Service, Department of Health and Human Services, Washington DC 1999; and Burns, B., Hoagwood, K. and P. Mrazek, Effective Treatment for Mental Disorders in Children and Adolescents. *Clinical Child and Family Psychology Review*, Vol 2, No. 4. 1999.

2. Georgia, Maryland, Kansas, Kentucky, Nevada, Oregon and Pennslyvania. *Making Sense of Medicaid for Children with Serious Emotional Disturbance*, Washington DC: Bazelon Center for Mental Health Law (September 1999).

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#5

Covering Intensive Community-Based Child Mental Health Services Under Medicaid

Summer Camps

Children with serious mental or emotional disorders need structured environments and continual assistance in improving their social skills, coping skills, anger management and behaviors. The long summer vacation can be an especially difficult time. Skills learned over the school year are lost, family relationships often deteriorate under the stress of having a child home all day and, with daily life lacking structure, a child's condition may well deteriorate. Therapeutic summer programs, such as summer camps, can fill this void in the service system at very low cost, while giving children a normalizing and enjoyable experience and offering families a break.

Service Description

While some states rely on continuation of other services (such as day treatment, case management, in-home services or behavioral aides) to carry children over the summer and other vacations, several have developed specific program descriptions to cover therapeutic summer camps. These camps offer a wide range of activities. Many are similar to those in a regular summer camp, but in a therapeutic camp the activities are specifically designed to address a child's mental health needs and are supervised by appropriately qualified staff. Sometimes an after-

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school program will extend its hours during the summer and provide these services.

Research Literature

Research on day programs has shown the effectiveness of a comprehensive array of services provided in a structured setting to children with serious mental or emotional disorders.[1] Controlled studies on summer camps are not available, but the activities furnished in these programs parallel many of the activities in day treatment programs.

Medicaid Coverage

Summer camp programs are normally covered under the rehabilitation option. Covered summer camp services must be therapeutic, furnished by qualified staff with appropriate supervision and part of the child's plan of care. Medicaid does not cover fees for community recreational opportunities, such as membership in a YMCA or YWCA, fees for a regular summer camp, riding lessons, fishing lessons or music lessons.

Coverage in States

Four states have detailed definitions of summer camps.[1] State rules covering summer camps often address the following issues:

- **Purpose of service**: to provide a structured program during weeks when children are not in school, so as to continue services in the child's plan of care and avoid the loss of gains made during the school year. Camps may combine clinical monitoring and services along with developmentally appropriate therapeutic activities. Services are designed to develop skills and maintain or improve functioning and behavior.
- **Eligible child**: children with serious mental or emotional disorders or serious emotional disturbance. Further requirements may be imposed, such as requiring that the child have a documented need for this type of program.
- **Activities**: Summer camps offer therapeutic recreation or recreation therapy, defined to include structured goal-oriented activities designed to assist children in building social skills and enhancing self-esteem. Group activities are emphasized and designed to promote developmentally appropriate behaviors and improve skills. A range of specialized therapies can be offered, including art, music, dance and movement, play, recreational or occupational therapies. Programs may also offer individualized behavioral management. Activities may be physical ly active or passive, and can be designed to assist children in self-expression, social interaction and self-esteem enhancement. Clinical services are often built into the programs, including individual or group therapy and medication management. In some programs, community-integration activities are covered, to assist the child in developing appropriate behaviors and responses in the community context. All therapies and activities must be designed to meet specific goals in the

child's plan of care. Families are engaged in the program and particularly in the treatment planning, and programs may require families to participate in certain activities.

- **Residence of child**: Children live in the community during the rest of the year; during the summer camp they may live at the camp or commute from home.
- **Goal of services**: to enhance interpersonal and social skills and teach decision-making, problem-solving and coping skills. Programs are also designed to maintain functional and behavioral gains from the school year.
- **Service planning**: Children are generally required to have a plan of care that specifies treatment goals and objectives, and a physician or other qualified professional must prescribe or recommend a therapeutic camp as medically necessary. Services furnished in a therapeutic summer camp must be integrated into an overall plan of care for the child.
- **Delivery site**: Services are generally provided in an outdoor environment, over the summer or other vacation times, and designed to provide a therapeutic experience in a normalized setting.
- **Qualifications of staff**: Program staff may include clinical personnel and the director may be required to be a mental health professional. Specialized therapies, such as art or music, must be furnished by staff with appropriate qualifications in those therapies (such as from a national credentialing entity). Programs may be required to have a registered nurse. Other mental health workers must meet state-specified requirements for education and training and must have appropriate supervision.
- **Length of intervention**: Camps run for various periods of time during school vacations. Normally, camps operate five days a week and run either all day or half day.
- **Prior approval**: The therapeutic summer camp must be recommended by a physician or other practitioner of the healing arts, and must be recommended as part of a child's plan of care. All states require, or assume, that the child has a comprehensive plan of care of which the therapeutic summer camp is one component.
- **Services specifically not covered**: Recreational activities that do not have a therapeutic goal or are not providing specific skill-building opportunities are not covered.
- **Other issues**: Summer camp providers must meet appropriate state standards, including qualifications of staff and program.
- **Issues in securing Medicaid approval**: Summer camp programs are often listed under Medicaid as an all-inclusive service, much like a day treatment program, and are then billed at a daily rate. Under these circumstances, other Medicaid services, such as clinic services, cannot be billed separately by the program. Alternatively, the specific treat-

ment-related services of a summer camp program might be billed, such as time for behavioral aide services, counseling, etc. In this case, each service will be billed and reimbursed separately. Definitions for summer camp services must make clear that these services are part of the child's overall plan of care and that activities are related to symptom management, skill-building and improvement or maintenance of functioning. Activities that are purely recreational or purely social are not covered under Medicaid.

Notes

1. *Mental Health: A Report of the Surgeon General*, U.S. Public Health Service, Department of Health and Human Services, Washington DC 1999; and Burns, B., Hoagwood, K. and P. Mrazek, Effective Treatment for Mental Disorders in Children and Adolescents. *Clinical Child and Family Psychology Review*, Vol 2, No. 4. 1999.

2. Florida, Kansas, Kentucky, Pennsylvania and Vermont. *Making Sense of Medicaid for Children with Serious Emotional Disturbance*, Washington DC: Bazelon Center for Mental Health Law (September 1999).

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#6

Covering Intensive Community-Based Child Mental Health Services Under Medicaid

Therapeutic Nurseries and Preschools

Therapeutic nurseries and preschool programs provide early intervention for very young children with or at high risk for serious mental disorders. States use these terms interchangeably, although in some states, therapeutic nurseries serve infants and very young children while preschools serve 3- to 6-year-olds. Children may be placed in such programs after exclusion or explusion from a regular child-care program or because their tenure at home is in jeopardy. Children in such programs often have a caregiver with a mental illness or other disability or have significant parent-child relationship problems.

Service Description

Early childhood therapeutic nurseries and therapeutic preschools provide a range of developmental and behavioral interventions to promote attachment and intellectual development, and may also include attention to nutritional needs, physical therapy or other health services. Participating children may suffer from traumatic stress disorder, interaction disorders such as separation anxiety, oppositional disorder, phobias, sleep and eating disorders, self-abusive behaviors, attention-deficit disorder or disorders relating to communicating. They may also suffer the effects of parental drug or

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alcohol addiction or use during pregnancy or parental depression. Programs combine child care with therapeutic activities and family education and training.

Research Literature

The few studies of therapeutic nurseries and preschool programs that exist have found positive outcomes. Children in these programs have made gains—particularly the children with developmental delays and related emotional and behavioral problems. Children with primarily behavioral and emotional problems made gains mostly in impulse control. For programs to be effective and gains sustained into later childhood, research has found that children should remain in the program for some time, up to two years. Another finding is that the family plays a significant role in outcomes for the child after the service ends.[1]

Medicaid Coverage

Therapeutic nurseries and preschool programs can be covered under either the clinic option or the rehabilitation option. Sometimes they are listed as separate services, with specific rules; in other states they fall under the description of day treatment programs.

Coverage in States

Six states have detailed definitions of the services of therapeutic nurseries and preschools.[2] State rules covering these programs often address the following issues:

- **Purpose of service**: to provide early intervention to ameliorate mental and emotional disturbance in young children and address developmental delays, behavior or adjustment problems in children who are at risk of more serious disorders.
- **Eligible child**: Only very young children are covered—as a rule, children from birth to 3 in therapeutic nurseries and children from 3-6 in therapeutic preschools. But there is considerable variation, and some programs offer services into the early years of elementary school. Eligible children have or are at risk of (as evidenced by developmental delay or atypical development) more serious, diagnosable disorders if the intervention is not furnished, and family counseling, play therapy or other less intensive outpatient interventions would not be enough for them. Eligibility criteria may require the child to have been excluded from more than one day-care program due to behavioral or developmental problems. Children may need to show significant problems in development, such as attachment, emotional, social, cognitive, self-concept, self-help, behavioral, receptive/expressive language and physical development.
- **Activities**: Covered interventions include testing and evaluation, individual and family therapy, play therapy, parenting classes, home visiting and therapeutic day care. Therapeutic day care emphasizes

milieu treatment and includes individual and group activities to stimulate age-appropriate behaviors and emotional and developmental progress—all designed to improve the child's level of functioning. Families are significantly engaged, and sometimes required to attend a specified number of family therapy sessions. Family education and training are also furnished. For extremely young children, the emphasis is on relationship-building. For older preschoolers, programs focus on building the capacity to interact appropriately with each other and with adults so that children enter school ready to learn. Much of the time in the program is devoted to arts and crafts, movement, exercises and play therapies. Children receive positive attention, supported peer play, coaching, prompting, role-playing opportunities and other activities to build social skills, improve affect and language skills, develop appropriate relationships and reduce behavior problems. Most programs also furnish health services, physical, speech and language therapy, nutrition services, audiology services, nursing, and occupational and physical therapy as needed. Families may receive coaching in parenting skills, family therapy and home visits. Cultural issues are recognized and cultural competence is emphasized in family services.

- **Residence of child:** Children live in the community. Programs may emphasize services to children in protective custody or at risk of being placed in protective custody.
- **Goal of services:** to improve children's mental and emotional health and well-being and to ensure that they have the social and emotional competencies essential to school success. Skills to be enhanced include motor skills, social, intellectual, self-help and emotional skills. Building strong relationships, which form the foundation for social and emotional competence in early childhood, is also a key goal.
- **Service planning:** Children must have an assessment and a treatment plan, generally developed by a multi-disciplinary treatment team, and focused on child and family strengths as well as the presenting problems. Children receive a comprehensive developmental assessment, which might include play assessment, observations and use of the Preschool Early Childhood Functional Assessment Scale or the Child Behavior Checklist.
- **Delivery site:** Some providers are attached to school settings or part of HeadStart programs, others are freestanding or connected to a community mental health agency. When programs are located within other sites, such as schools or mainstream day-care programs, therapeutic nursery/preschool staff may provide mental health consultation to teachers and other personnel. Several programs provide services both on and off site, especially home-based services.

- **Staff qualifications:** Staff must be appropriately credentialed and demonstrate certain experience or skills to work with at-risk and mentally and emotionally disturbed infants and toddlers. Mental health professionals and teachers participate as members of the treatment team.
- **Length of intervention:** Services must generally be provided for a specified number of hours per day (normally half-days, e.g. four hours) and offered for a specified number of days per week, up to five. In most states, children can stay in the service as long as medically necessary and there is no pre-determined limit. Other states limit the number of days or units of service per month or per year. Generally speaking, lengths of stay average more than a year, although some programs are crisis-focused.
- **Prior approval:** Referral for these services can be made by mental health professionals, educators and others. A physician or other mental health professional is required to refer children for the service and in some states a physician must sign off on the treatment plan and conduct periodic reviews of the child's progress.
- **Services not covered:** Educational services are specifically excluded.
- **Other issues:** Ratio of staff to children is often specified (such as staff-to-child ratio of 1:2 or 3 infants and 1:4 or 5 toddlers). Transportation to the program is often an integral component.
- **Issues in securing Medicaid approval:** Medicaid requires that all children served have a diagnosis. As a result, programs for very young children may be unable to furnish services in a preventative manner. Children must have a plan of care and their treatment must be authorized by an appropriately qualified professional. Because of these requirements, programs often focus on children who already have a high level of need and preschoolers may be required to exhibit symptoms and behaviors that result in their meeting state definitions of serious emotional disturbance. However, programs can also provide services to children with less serious mental and emotional disorders, particularly if they are at risk of developing more serious emotional disturbance.

Notes

1. Kutash, K. and V. Robbins Rivera, *What Works in Children's Mental Health Services? Uncovering Answers to Critical Questions.* Florida Mental Health Institute, Research and Training Center for Children's Mental Health, University of South Florida. Paul H. Brookes Publishing Co., Baltimore. 1996.

2. District of Columbia, Maryland, Oklahoma, Oregon, South Carolina and Tennessee. *Making Sense of Medicaid for Children with Serious Emotional Disturbance,* Washington DC: Bazelon Center for Mental Health Law (September 1999).

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